NATIONAL INSTITUTES OF HEALTH
WARREN GRANT MAGNUSON CLINICAL CENTER
NURSING DEPARTMENT

PROCEDURE: Physical Intervention with an Aggressive Patient

Approved:

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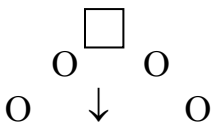
PROCEDURE: Physical Intervention with an Aggressive Patient

A. Essential Information

- Physical containment holds are a type of physical restraint.
- The goal of physical intervention is the behavioral control, care, and treatment of the aggressive patient.
- Documentation includes MIS Interdisciplinary Notes as well as NIH-2797: Seclusion and Restraint Posting Form Behavioral Health Setting if physical intervention is used as sole method of restraint.
- Attendance at the CCND Aggressive Behavior/Violence Prevention-Intervention Workshop AND yearly competency checks are required to practice physical intervention techniques.

B. **STEPS**	**KEY POINTS**
1. Analysis of the situation	1. In order to make a statement about the behavioral possibilities for the patient in the very immediate future
2. Plan - formulated from the results of the analysis a. Determine goals of intervention. b. Choose a team leader to be in charge of a three-person or preferably four-person intervention team. The team leader may be: 1. first person on the scene. 2. person who knows the patient the best. 3. most knowledgeable and confident person.	2b. A four-person team is preferable in case the two-person control team requires assistance to contain the patient. However, two staff can physically manage a patient in the control/hold positions.
3. Preparation a. self 1. psychological (gathering control over own emotions and feelings) 2. physical (removing jewelry, pens from pockets, neck ties, eye wear, etc.) b. team Final instructions to team members and staff: team leader assigns right arm, left arm, right leg, left leg, in case additional limb control is necessary. c. environment 1. Remove other patients and visitors from the area; move chairs, etc.	
4. One staff person approaches patient from slightly to the left and one person slightly from the right, leaving the patient with 1.5 - 3 feet of personal space. The one or two remaining staff form a "V" shape in relation to the patient. This should appear as a triangle with the patient at the center point.	4. The proper approach always leaves the patient a perceived escape route.  Staff generally face same direction as the

patient, providing directional guidance.

5. If the patient strikes out, the staff person targeted grasps the patient's wrist. The other staff grasps the patient's other wrist.
6. The patient's arms are then brought to his side and then back until upright with palms up or forward. Elbows are locked, and shoulders are pushed down below patient's hip level. By pivoting and stepping in front of the patient, his forward momentum is then stopped. Staff use hips and thighs to hug inward towards each other, taking tiny steps forward. This reduces patient mobility and increases support.
6. Without using own muscle power, the staff member is controlling the patient by taking advantage of the patient's forward momentum. The full containment position reduces the opportunity to struggle or potentially loosen staffs' control position. The patient is dependent on the staff for balance and security.
7. The third and fourth staff members assist to help maintain the patient's balance and confine his movements by holding the patient's belt or other article of clothing around his waist from behind, or pushing down on shoulders from the front.
8. **AVOID, IF AT ALL POSSIBLE, TAKING THE PATIENT TO THE FLOOR.**
8. Statistically, this is when injuries most often occur.
9. Upon leader's command, both staff members, while holding the patient's arms, will shift from the control position to the walking upright position. Staff member to the rear will continue to help balance the patient by holding on to the belt or waist clothing.
9. The preferred mode of moving the patient is the triangle team transport technique.

Positional transitions are times of lessened staff control, thus any transition requires the team's organized attention on the leader.

10. The patient is then walked briskly to the designated area.
11. If patient requires immobilization during the walk, staff may shift hips further behind the patient and position patient's arms further behind his back. Then position the patient's arms closer to the body of the staff. The staff push against each other "back to back."
11. Staff can also return to the more secure control position as necessary during transport.
12. If the patient is highly resistive, the team leader may command a take down and hold. The control/hold positions may be sufficient to manage the patient until his/her cooperation is achieved. When patient is more cooperative the upright transport method may be tried again.

    Note: **If the patient continues to be resistive and the leader and team determines the patient cannot be safely walked to seclusion, the patient may be secured in four point locked leather restraints attached to a wheeled hospital bed and transported to seclusion.**
12. This method is to be used only when previous techniques fail. Statistically, most injuries occur during floor struggle.
13. The patient then is lowered prone to the floor
13. Every attempt must be made to maintain close

in a "take down" technique. Staff should be as close to the patient's body as possible. Staff's hips should be in contact with the patient's hips. Instruct pt. to kneel. Staff use hips and thighs to hug inward towards each other, taking tiny steps forward. The staffs' bodies act as a surface upon which the patient is gradually and safely lowered to the floor. The team members in the rear control the patient's legs. **AVOID ANY PRESSURE TO JOINTS, ESPECIALLY KNEES.** The patient is then held in a control position on the floor. Again, 3-4 staff members can control most patients.

proximity between staff members' and patient's hips: this position provides the stability necessary to lower the patient gradually and safely to the floor.

14. Staff should not be in a hurry to transport the patient. If indicated, medication may be given intramuscularly at this time. After the patient has calmed somewhat, he may be transported using the upright walk technique. Judge patient's ability to safely cooperate by gauging muscle relaxation, ability to listen and concentrate (e.g., ask patient to count backward from 5), and to follow simple instructions, (e.g., "Stop struggling.").

14. With time, patients tire and may be more easily and safely transported.

15. Transportation of the patient should be a steady movement--**DO NOT RUSH**.
16. In the seclusion room, lower patient to the mattress according to procedure #13. Legs are crossed at ankles.
17. Potentially dangerous objects are removed from patient's person (jewelry, shoes/laces, belts, sharps, etc.)
18. Leader directs each staff to release limbs: feet first, then arms one at a time in rapid succession.

18. If staff remaining lose control of patient, released staff return to floor control position.

19. Involved staff review the procedure immediately following the intervention.

19. Critical review session provides opportunity to evaluate efficacy of physical intervention and provides opportunity for professional expression of feelings evoked by aggressive behavior. As part of follow-up and therapeutic care planning, criteria for discontinuing seclusion or restraints are established now**.** The team identifies factors contributing to the patient's immediate and ongoing loss of control, and incorporates this assessment into preventative care planning.

B. Documentation

1. If use of physical intervention/team control hold is the sole method of physical restraint used, document in the approved electronic record assessment, intervention, and outcome including:
   a. Patient's behaviors precipitating the need for team control hold/transport;
   b. less restrictive interventions, which were unsuccessful in helping the patient re-establish self-control;
   c. extent to which patient was able to cooperate with procedure;
   d. specific interventions utilized and patient's response:
   e. use of team control hold/transport per Nursing Department procedure;
   f. date, time, and duration of hold procedure;
   g. names of staff involved in procedure;
   h. patients response to intervention;
   i. readily observed physical condition of the patient;
   j. any injury to patient or others;
   k. Specifics of communication with clinically and administratively responsible parties when team control hold proves inadequate to maintain patient's safety;
   l. Notification of patient's family, parent or guardian as applicable.
   m. Complete NIH-2797 Seclusion and Restraint Posting Form Behavioral Health Setting
   n. Report use of ANY hands-on intervention.
2. If use of physical intervention results in locked seclusion or use of restraint equipment, complete
   a. Behavioral Health Restraint and Seclusion Log (NIH-2580-1 rev 5-03)
   b. Seclusion and Restraint Posting Form Behavioral Health Setting (NIH-2797)
   c. Restraint or Seclusion Licensed Independent Practitioner (LIP) Progress Note (NIH-509)
   d. Continued Restraint or Seclusion Authorization by Clinical Director or his/her designee For Behavioral Health Patients Only (NIH-509)
   e. Report use of any hands-on intervention AND use of restraint equipment or locked seclusion.

D. **References**

1. CCND Standard of Practice "Nursing Prevention and Management of Aggressive Behavior" 1995, (revised 9/97, 9/98, 11/99, 10/03).
2. Clinical Center Policy and Communications Bulletin, Medical Administrative Series, M-94-10 (revised 04 September 2003). Subject: Restraint and Seclusion.
3. National Crisis Prevention Institute: Nonviolent Crisis Intervention Training Program. Brookfield, WI. 2002.